Agreement to Pay Benefits

(formerly: Memorandum of Agreement)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

SEE INSTRUCTIONS ON REVERSE SIDE

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code/PEO Ref. #	Insurer location
	Insurer claim number	

Employer

Name of employer (see Employer's First Report)		Address
Phone number	Federal Tax Identification Number	Is this worker covered by PEO policy? ☐ Yes ☐ No

Employee

Name of employee	Phone number
Address	Date of birth
	Social security number

Time and Place of Accident

City or county where injury or illness occurred		Cause of injury or illness
Nature of injury or illness, including parts of body affected		
Date of injury or illness	List first seven days of incapacity	Pre-injury Average Weekly Wage

Terms of Agreement

We certify that the facts relating to this accident are correct as presented on this form, and agree that the employee shall receive the compensation or benefits indicated below until terminated in accordance with the provisions of the Workers' Compensation Act.

Temporary Total

$_____ shall be paid per week beginning _____ based on a pre-injury average weekly wage of $_____.

Temporary Partial

$_____ shall be paid per week beginning _____, the date on which claimant returned to work at a weekly wage of $_____ compared to a pre-injury average weekly wage of $_____.

Permanent Partial

$_____shall be paid per week for _____ weeks beginning _____, based on a _____% loss (or loss of use) of the _____, and a pre-injury average weekly wage of $_____. This compensation shall be payable _____.

Medical only

_____ (Check here.) The parties agree to an award for payment of medical bills related to the compensable injury.

Signatures

	Print Name	Phone	Date
Employer		( )	/ /
Employee, guardian, or committee		( )	/ /
Insurer or authorized representative (signature of processor)		( )	/ /

Name and address of Insurer	(This space reserved for Commission use)
Name and address of employee's attorney (if represented)	Fee Approved by Date

This report is required by the Virginia Workers' Compensation Act

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Agreement to Pay Benefits
VWC Form No. 4

1. This form is completed whenever a claim has been accepted as compensable and the injured employee is entitled to an award. This Agreement to Pay Benefits provides the basis for the initial award of compensation, and contains sufficient information to establish the essential elements of a compensable claim. Submit the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. For subsequent periods of compensation benefits, a Supplemental Agreement to Pay Benefits (VWC Form No. 4A) or a Supplemental Agreement to Pay Varying Temporary Partial Benefits (VWC Form No. 4G) must be filed.

2. The information at the top right of the form should be provided by the insurer. Please note that the insurer code refers to the five-digit numeric code assigned by The National Counsel on Compensation Insurance (NCCI). Self-insured employers are assigned a similar five-digit code number by the Virginia Workers' Compensation Commission.

3. Incomplete or illegible forms will either be returned to the insurer for proper completion or they will be rejected.

4. When filling out this form, please be sure to provide a brief description of how the accident or illness occurred in the "Cause of Accident" box. Please indicate **all** parts of the body affected and which are accepted, in the "Nature of Injury" box. If the "Nature of Injury" is not indicated on the form, the form will be rejected.

5. Note that compensation is paid beginning with the eighth (8^{th}) day of disability resulting from a work related accident or illness. If the disability period exceeds more than 21 days, then compensation is owed retroactively for the first seven (7) days of disability. The first seven (7) days of disability includes all days or parts of days when the injured employee was unable to earn a full day's wages, or was not paid a full day's wages, due to the injury.

6. When an employee receives full wages during disability, these days are to be counted towards the waiting period and any subsequent days of disability. Agreement forms need to be completed in their entirety, giving dates and amounts the employee would have been entitled to receive in compensation benefits covering all periods of disability.

7. **Definition of Types of Benefits**:
   Temporary Total (TT) Disability – Injured employee is totally disabled for work, and is entitled to receive compensation for a period of total wage loss, based upon 66 2/3% (.66667) of the pre-injury average weekly wage.*
   Temporary Partial (TP) Disability– Injured employee is partially disabled for work, but is entitled to receive compensation for a period of partial wage loss, based upon 66 2/3% (.66667) of the difference between the pre-injury average weekly wage and the post (or current) average weekly wage.* Forms received without specific dollar amounts or those that reflect the word "Various" will be rejected.
   Permanent Partial (PP) Disability – Injured employee is entitled to receive compensation based upon the loss of use or the loss of a ratable body member, based upon 66 2/3% (.66667) of the pre-injury average weekly wage for a specified number of weeks, pursuant to Va. Code §65.2-503. Please attach a copy, to the agreement form, of the doctor's report or the amputation chart that supports the permanency rating.*
   Medical Award – The parties agree that the employee sustained a compensable injury for which the employer and insurer will accept responsibility only for the medical expenses incurred as a result of a work related injury or occupational disease.
   *Compensation rate is subject to yearly maximum and minimum allowances.
   *All wage information and compensation rate(s) reflected on the form(s) should be based on weekly figures.

8. The signatures of the employee and a representative of the employer or insurer (including the insurer's name and address) are required. If these signatures are missing, this form will be returned.

9. **Forms**: Additional copies of this form are available without cost by writing to the Commission. This form is also available on the Commission's website, at www.vwc.state.va.us. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address.

10. For questions or assistance with completing this form, please contact the Awards Unit using the Commission's toll-free number at (1-877) 664-2566.